



ASAM American Society of
Addiction Medicine

Supporting People with Addiction in Criminal Justice Settings

The COVID-19 pandemic is presenting unprecedented challenges for criminal justice systems across the world. During this crisis, individuals with addiction should continue to receive treatment in these settings. This guidance is intended to provide guidance on issues related to adaptations criminal justice systems and addiction treatment providers may need to make to address individuals with addiction and criminal justice involvement during the COVID-19 crisis.

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Reopening Considerations

While many places across the country are starting to relax physical distancing restrictions, the COVID-19 pandemic is not over. Communities and treatment programs across the country remain at risk for increasing population prevalence over time. Providers and programs should continue to implement policies and procedures to reduce the risk for coronavirus transmission, based on national scientific guidance and informed by the available data and guidance in their state and local areas. In addition, clinicians and clinical programs should prepare for potential spikes in transmission in their community and program. Programs and providers should consider:

- Maintaining or implementing an incident command structure to prepare for and address any issues that arise due to COVID-19
- Reviewing current infection control processes, including the extent to which staff and patients are adhering to them.
- Assessing what worked well in your initial response and where there may be room for improvement, updating related policies and procedures as needed.
- Assessing your program or practices' potential needs related to:
 - Personal protective equipment and other supplies needed to control and mitigate the spread of the coronavirus.
 - Staff training
 - Staff support

- Technology to support telehealth
- Addressing the evolving phases of the epidemic and how to prepare for the next stages in your community.

Treating Addiction in Jails and Prisons During the COVID-19 Crisis

While jails and prisons across the country are struggling to address the COVID-19 crisis it is important to remember we continue to face an addiction crisis. Individuals with addiction should continue to receive treatment, including with effective medications, during incarceration. Despite the realities of the pandemic, jails and prisons should not halt implementation of addiction treatment programs. However, there may be additional considerations regarding choice of medication and medication formulation during the COVID-19 crisis. See [ASAM's COVID-19 guidance on Medications, Formulations, and Dosages](#).

Considerations for Reentry of Individuals with Addiction During the COVID-19 Crisis

Reentry is an incredibly vulnerable time for individuals with a history of addiction. In one study in Washington state, during the first 2 weeks after release from prison, the risk of death from drug overdose was 129 times higher than the general populations.¹ Other research clearly demonstrates that

¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836121/>

evidence-based addiction treatment reduces this risk.² Therefore, criminal justice systems must consider the risks associated with COVID-19 as well as the risks associated with addiction when planning for reentry.

The coronavirus presents unique challenges for criminal justice settings, particularly in jails and prisons where physical distancing may not be possible. Many jurisdictions are working to rapidly release incarcerated individuals who are at high risk for severe COVID-19 illness and those that pose a low risk to public safety. However, many individuals with addiction are being released from incarcerated settings with insufficient planning for ongoing addiction treatment post-release.

While reentry planning may need to be simplified and expedited as prisons and jails work to more rapidly release individuals into the community, for individuals with addiction, whether active or in remission, it is critical that overdose prevention, medication continuity, community treatment, and safe housing are addressed:

Overdose prevention

Individuals with active, or a history of, opioid addiction should be provided with naloxone upon release.

Consistent with ASAM's National Practice Guideline for the Treatment of Opioid Use Disorder, all individuals with addiction involving opioids as well as stimulants (because stimulant drugs may be adulterated with fentanyl or other opioids) should be given naloxone rescue kits prior to release and instructions on how to use them. Preferably, individuals would receive the actual rescue kit from the jail or prison prior to or at the time of release. If this is not possible, the jail/prison should consider working with local naloxone distribution programs, local or state health departments, or a local pharmacy to ensure that individuals in need can access naloxone upon release.

Medication Continuity

Individuals with addiction who are reentering the community should be provided a clear plan for uninterrupted supply of medications, including medications to treat addiction.

- There should be a clear chain of responsibility for ensuring that the individual maintains access to medications upon re-entry. For example, the probation or parole officer could be assigned the responsibility of following up with the individual and their community treatment providers to assure uninterrupted treatment.
- Individuals taking methadone for treatment of OUD should be proactively connected to a community opioid treatment program (OTP) with sufficient take-home doses until their scheduled visit with the community OTP. Ideally, this would stretch no longer than 48-72 hours post-release as evidence shows the longer the wait, the less likely someone is to engage in ongoing care. In addition, the transition should be carefully coordinated between the OTP that has been providing care to the patient during incarceration and the OTP that will provide care after community reentry.
- During the COVID-19 crisis, and despite best efforts for post-release care coordination, there may be a delay for individuals to effectively access addiction treatment in the community. As such, post-release planning is critical. Jail and prison staff should provide resources that can help

² <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2671411>

individuals with addiction continue effective treatments while reducing risks of COVID transmission. This ideally includes providing 30 days of buprenorphine upon release to individuals taking this medication for treatment of OUD. At a minimum, these individuals should be provided enough medication to cover the time until the individual can reasonably be expected to obtain follow up in the community.

- Ideally, coordination with a community prescriber prior to release would allow for a phone-based initial evaluation and establishment of concrete steps for follow-up post-release.
- Consider including refills with a “do not fill before” date if the likelihood of finding an available prescriber within 30 days post-release is small.
- The individual should also be provided guidance related to how to get refills if they are not able to access follow up care in a timely manner. For example:
 - Provide instructions regarding who they can reach out to for assistance if they are unable to access care and need more medication (e.g. their probation or parole officer, or the re-entry coordinator).
 - Provide guidance on options for low barrier access that might be in the community.
- Individuals receiving buprenorphine should be educated about and alerted to the need for safe, secure storage and the dangers of sharing medication with others. While diversion of buprenorphine may occur, current research suggests that most diverted buprenorphine is used for therapeutic purposes (i.e., to reduce withdrawal symptoms, reduce heroin use, etc.).³
- Patients taking non-controlled medications for treatment of OUD, alcohol use disorder or nicotine use disorder, should be given a 30-day supply of medication and proactively connected with ongoing care.
 - The individual should be provided guidance related to how to get refills if they are not able to access follow up care in a timely manner. For example:
 - Provide instructions regarding who they can reach out to for assistance if they are unable to access care and need more medication (e.g. their probation or parole officer, or the re-entry coordinator).
- Reentry planning from prison typically takes months of coordination. However, the urgencies of the COVID-19 crisis will necessitate more rapid planning for individuals with addiction. Many federal and state policies can create barriers to this process. Justice systems should work with their state and community leaders to try to reduce these barriers. This might include, for example, working with their state Medicaid Director to explore opportunities for supporting more rapid access to Medicaid, such as instituting a rapid application and initiation process for emergency access to Medicaid and working to automatically activate this upon re-entry.

Community Treatment Connection:

There should be a proactive plan for connection to community treatment.

³ <https://www.drugabuse.gov/publications/medications-to-treat-opioid-addiction/what-treatment-need-versus-diversion-risk-opioid-use-disorder-treatment>

- Some addiction treatment programs have stopped accepting new patients during the COVID-19 crisis. There may not be sufficient treatment capacity in the community. Consideration should be given to how the patient can access treatment. For example:
 - Are there local OTPs or buprenorphine providers that are taking new patients?
 - OTPs presently have no caps on the number of patients they can treat with buprenorphine. Current federal guidance provides flexibility for addiction treatment providers during this public health emergency (see ASAM's [Telehealth Guidance](#) and [Guidance for OTPs](#)). These waivers on regulations allow OTPs to initiate and maintain patients on buprenorphine through telemedicine, including telephone-based visits.
 - Is there a local federally qualified health center (FQHC) that can provide buprenorphine treatment?
 - Are there providers, within or outside of the community that can provide the necessary services through telemedicine for the patient?
- Consideration should also be given to the individual's access to healthcare coverage.
 - Can the patient afford their medications and clinical care? If not, are there community programs available to subsidize the individual's medication or treatment costs, e.g. FQHCs, 340b, pharmaceutical discounts, state or county programs?
 - Is the patient eligible for Medicaid or other health care coverage? What needs to be done to re-enroll the individual or reactivate their coverage?
- Consideration should be given to how the individual will participate in telemedicine-based appointments.
 - Does the individual have reliable access to a phone?
 - Could a phone be provided to them for this purpose? For example, through referral to the federal lifeline program that helps provide phones and limited minutes. https://www.fcc.gov/sites/default/files/lifeline_support_for_affordable_communications.pdf
 - Consider assigning a staff person to assist individuals with installing any required apps on their phones that will be needed to access the telehealth services they will be expected to use.
- Consider establishing telehealth services for addiction treatment, or contracting with addiction treatment providers who can provide telehealth services. These services can be used to provide reliable access to care (including treatment with opioid use disorder medications) to individuals with addiction immediately post-release.

Safe Housing in the Community: There should be a proactive plan for the individual's shelter/housing post-release.

The COVID-19 pandemic is likely to make it more challenging for individuals re-entering the community to find housing. Jails and prisons are high-risk environments for virus transmission. Relatives or friends, particularly those that are at risk for severe COVID-19 illness, may be unwilling to provide temporary housing. In addition, many residential addiction treatment programs and recovery residences are limiting acceptance of new patients/residents. Jails and prisons should coordinate with local and state partners to identify options for emergency or transitional housing.

Considerations for Treatment Providers Caring for Recently Incarcerated Patients with Addiction

Jails and prisons are high risk environments for the transmission of the novel coronavirus. Treatment providers/programs should assume that the patient may have been exposed to the virus and take precautions for infection control and mitigation as appropriate (See ASAM's [Guidance on Infection Mitigation in Outpatient Settings](#) and [Residential Settings](#)).

Role of FQHCs in Addiction Treatment During COVID

Federally qualified health centers (FQHCs) can play an important role in the ongoing care of recently incarcerated individuals with addiction because they are used to working with populations without insurance or with Medicaid. They have sliding fee scales and programming that allows patients to get medications at substantially reduced cost. Many FQHCs have existing office-based opioid treatment programs, and many have behavioral health staffing qualified to provide addiction treatment. Most aim to treat all patients including people who were formerly incarcerated with dignity and respect. Criminal justice systems should consider working with local FQHCs to support effective coordination of care upon reentry. Memoranda of understanding can facilitate processes for ensuring coordination of care and communication.

Considerations for Probation and Parole in the Supervision of People with Addiction

Probation and parole services can play an important role in supporting continuity of care as individuals with addiction are released from incarcerated settings. Individuals treated with medication for opioid use disorder are at significant risk of relapse and overdose if their medication is disrupted. Probation and parole officers can follow up to assist the individual to access needed medications and safe housing.

Probation and parole officers should also consider how to minimize person to person contact during the COVID-19 crisis.

- Transition to virtual meetings with individuals assigned to them whenever possible.
- Reinforce/praise individuals under community supervision who follow stay at home orders.
- Consider suspending or reducing drug testing requirements to minimize person-to-person COVID-19 transmission (see [ASAM's COVID Guidance on Drug Testing](#)).
- Facilitate virtual recovery support group meeting.
- Follow the recommendations of CDC and state/local governments to reduce transmission.

Probation/parole requirements should be modified to reflect what is reasonable in the current crisis for those individuals with addiction who are under their supervision. Probation and parole officers should connect with treatment providers to understand how these programs are currently operating and how the patient is expected to engage in treatment. Probation and parole officers should also be cognizant of the impact increased stress and anxiety caused by the COVID-19 crisis can have on people with addiction. It will be important to understand each individual's circumstances related to the pandemic and whether it warrants additional flexibility. For example:

- Is the individual at high risk for severe COVID -19 illness due to age or health conditions?
- Are they living with someone who is?
- Are they caring for someone who is ill with COVID-19 or COVID-type symptoms?
- Do they have children who need daily supervision and/or support with schoolwork?

Probation and parole officers should also consider the standards they apply to revocation of probation or parole during the COVID-19 crisis. Relapse is common in patients with addiction, particularly during times of significant stress. Relapse or other symptoms of addiction should be addressed through changes in the person's treatment plan; they should not be used as the basis for reincarceration. The National Association of Drug Court Professionals (NADCP) recommends against issuing a warrant just for relapse⁴:

“Issuing a warrant is not recommended just because the participant has relapsed, especially when treatment court team members have maintained contact. In areas with shelter-in-place orders, the participant may stay in touch through phone calls, Skype, or some other electronic means.

Remember, there are collateral consequences associated with arrest and custody. Courts are operating at reduced capacity. As a result, the participant may be in custody for a period of time before he or she sees the judge. As always, judges should balance the need to apprehend the participant against the cost of incarceration, such as loss of Medicaid, leaving children without a caregiver, loss of housing, and perhaps most importantly, loss of hope.”

⁴ <https://www.nadcp.org/covid-19-resources/hot-topics/>